

Summer Explorations at Missouri School for the Blind Application

Student's Name: _____ Age: _____ Grade: _____

Visual Diagnosis: _____ Acuity: _____

Check which *Summer Explorations* courses your student is interested in attending:

Session I:

- Camp Abilities 2017
 - Ages 10-16
 - July 9-14, 2017
- Explorations in Accessible Travel
 - Grades 3-8
 - July 17 – 21, 2017
- Explorations in Culinary Arts
 - Grades 6-12
 - July 10- 21, 2017

Session II:

- Explorations in STEM
 - Grades 3-8
 - July 24-August 3, 2017
- Explorations in Performing Arts:
Summer Drummin'
 - Grades 6-12
 - July 24-August 3, 2017

Session I and II:

- Independent Living
 - Ages (16-21)
 - July 10-August 3, 2017

For Office Use Only:

Sessions Accepted:

Transportation:

Dorm:

Special Needs:

*If your student is interested in attending more than one session we will make *every* effort to accommodate them on a first come, first serve basis. However, our space is limited this year so please indicate a first and second choice if we just cannot accommodate your student for both weeks.

1st Choice: _____; 2nd Choice: _____

Residential Services:

- I would like for my child to stay at MSB during their Summer Program and participate in the Residential Program
- My child will not stay at MSB during their Summer Program and I will provide their transportation to and from MSB daily.

Contact Information

Custodial Parent/Guardian:

Last Name: _____ First Name(s): _____
Home Address: _____ City/State: _____ Zip Code: _____
Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____
Cell Number: (____) _____ - _____ E-mail: _____
Preferred method of contact: _____

Non-Custodial Parent/Guardian:

Last Name: _____ First Name (s): _____
Home Address: _____ City/State: _____ Zip Code: _____
Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____
Cell Number: (____) _____ - _____ E-mail: _____
Preferred method of contact: _____

Emergency Contact:

Last Name: _____ First Name (s): _____
Home Address: _____ City/State: _____ Zip Code: _____

Home Phone: (____) _____-_____ Work Phone: (____) _____-_____

Cell Number: (____) _____-_____ E-mail: _____

School Information:

School District: _____ School Currently Attending: _____

Contact Person: _____

Address: _____ City/State: _____ Zip Code: _____

Phone: (____) _____-_____ E-mail: _____

Educational/Instruction Overview

Mainstreamed?

- Yes
- No

Reading/Learning Media:

- Regular Print
- Large Print, Font Preference: _____, Size: _____
- Braille
- Tape/Auditory

Does your student have an assistant?

- Yes
- No

If you answered yes, for what purpose?

- School work/Academic Support
- Vision Support without Academic Intervention
- Transfers/Physical Needs
- Other: _____

What Assistive Technology Devices does your student regularly use?

Is there anything else we should be aware of in planning for your student?

- Additional Disabilities, List: _____
- Special Dietary Needs: _____
- Special Transportation Needs: _____
- Behaviors: List: _____
- Typical Leisure Activities: _____
- Other: _____

Permissions

Photo/Video/News Print/Television/Radio – I hereby authorize MSB, with the approval of school officials to allow the use of pictures and/or voice reproductions of my child and/or the publications of any child's work and his/her name, and birthday for the purpose of educational information, public relations, school year book, school publicity and other beneficial endeavors, as long as such usage is not for the financial or personal benefit to any individual and/or groups or private company.

Circle one: **Yes** **No**

Internet/Computer Usage – As the parent or guardian of this student, I have read MSB's Internet/Computer student agreement. I understand that access is designed for educational purposes. I also understand that MSB is employing monitoring procedures and software to access the Internet. However, I recognize that it is impossible for MSB to restrict access to all controversial materials and I will not hold them responsible for materials acquired on the network. I hereby give permission to provide independent access to the Internet.

Circle one: **Yes** **No**

General Events – Permission is granted for my child to attend field trips and activities of which the school approves. I release MSB from responsibility connected with illness, accidents, damages or bodily injury incurred during the trip. EXAMPLE: Educational, Recreational and Athletic events.

Circle one: **Yes** **No**

I understand that the permissions and authorizations granted on this form will remain in effect as long as my child continues to be enrolled at MSB. I also understand that I can change any permission or authorization at any time by writing to the Assistant Superintendent.

Date

Signature of Parent/Guardian or Student over 18

The following information must be received by MSB by **May 1, 2015** for consideration in a *Summer Explorations* course:

- Completed Application

Current IEP

Mail registration to:

Missouri School for the Blind
Attention: Joy Waddell
3815 Magnolia
St. Louis, MO 63110

-OR-

E-mail

joyce.waddell@msb.dese.mo.gov

Fax:

(314)776-1875

If you have further questions or need additional information, please contact:
Joy Waddell, Assistant Superintendent; Phone: 314-776-4320 ext. 1140

Summer Explorations Health Form

Last Name: _____ First Name: _____

SS#: _____ MCD#: _____ D.O.B: _____

INS. GROUP # _____ Name of Insurance _____

received a copy of the cards

Student is allergic to Penicillin no yes

List any other medication allergies _____

Food/other Allergies _____

Please check all that apply:

- ADHD
- Allergic to bee stings/ peanuts EPI-PEN JR. OTHER _____
- ASTHMA
- CONTACTS GLASSES
- DIABETES INSULIN NO YES PUMP _____
- HEADACHES MIGRAINES
- HEARING AIDS
- HEART PROBLEMS _____
- SEIZURES DIASTAT NO YES Dose _____
- SICKEL CELL ANEMIA
- STOMACHACHES

List medication to be given:

I _____ The parent of the above named student give my permission to the nursing staff of M.S.B. to administer first aid and medications and treatments as prescribed by my child's physician. I understand that all medication to be given at school must be written on a doctor's prescription form to be kept in the health center. This prescription should include a medication for pan/fever. (ie. Tylenol/Ibuprofen)

Parent Signature: _____

Primary Physician Name & Telephone number: _____

Yes, my child's Immunization/Exemption for this school year is up to date and on file at L.E.A.

Student home schooled Yes No

If yes, you must provide a copy of your child's immunization record.

Parent Signature: _____

Lice treatment N/A 1-2 weeks ago More than a month ago

Summer Explorations Urgent Care and / Or Emergency Treatment
Please check one of the following boxes.

- We (I) the parent(s)/legal guardian of _____ consent to urgent treatment at a clinic, office or hospital and/or emergency treatment at a local hospital/In case of serious illness or injury where immediate care is needed, the MSB Health Center personnel or other school representative has my permission to contact appropriate emergency medical services. The emergency medical service has my consent to provide treatment as they deem necessary and to transport my child. We (I) consent to treatment, surgery, anesthesia, admission and discharge as deemed necessary by the attending physician. We (I) authorize the Missouri School for the Blind to release to the physician, hospital or clinic any relevant information necessary for treatment.
- We (I) do not authorize the treatment of our child by a hospital, clinic, etc. in case of an emergency. We would like to be notified and consulted prior to.

Parent/Legal Guardian Signature: _____ Date: _____

Relationship to Student: _____